EXHIBIT F

Wexford Health
SOURCES INCORPORATED

Medical Policies and Procedures

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PREFACE

This manual is intended to serve as a reference tool for physicians practicing medicine in the jails and prisons served by Wexford Health Sources, Inc. The manual contains clinical pathways, treatment protocols, and algorithms designed to ensure a standard level of quality and care at Wexford sites. The goal of each clinical pathway is to assist the physician in reaching the best possible outcome for each patient, while reducing opportunities for errors or inefficiencies. Wexford's physicians should incorporate the tools in this manual into daily practice.

The manual has been developed, and is maintained, by the Medical Advisory Committee of Wexford Health Sources. This committee is composed of clinical and administrative peers charged with developing consensus on clinical issues utilizing the most recent professional standards, evidence-based studies, and accepted practices.

Clinical pathways do not replace sound clinical judgment, nor are they intended to strictly apply to all patients. The specific strategies and pathways presented in this manual provide a clinical management approach, but their application is a decision made by the practitioner accounting for individual circumstances.

Medical management and information is continually changing as better treatments, testing, or approaches are learned. Consequently, some items in this manual may become obsolete and, as a result, this manual will continually evolve. **Physicians practicing at Wexford sites are encouraged to assist in keeping this manual updated and useful by presenting new information, sharing successful clinical approaches, and informing of adverse or suboptimal outcomes.**

As always, Wexford encourages its practitioners to utilize all accepted resources in providing care, as well as the leadership and advisement of its varied staff of medical directors and administrators. The "Quest for Excellence" is never complete.

TABLE OF CONTENTS

Separate Manuals

ARNP Treatment Protocols
Disaster Management
Chronic Care Guidelines
Infection Control Manual
Medical Director Orientation
Mental Health Policies and Procedures
Nursing Treatment Protocols
Nursing Orientation Manual
Operations (Jails, Juveniles, Prisons)
Patient Education Manual
Pharmacy Manual
Physician's Handbook
Telemedicine Manual

DENTAL POLICIES

PREFACE

The development of this technical instruction incorporates input from other Wexford Health Sources, Inc departments. The intent is to serve as an effective guide for dental services and to set forth standards for contracted dental services.

The enclosed guidelines and standards established herein are subject to ongoing additions, deletions, or changes as the delivery of quality health care is a dynamic process.

Additionally, it must be stated that the following procedure guidelines do not supersede any contracted entity policy and guidelines, but serve as supplemental information in the absence of client policy and guidelines for dental services.

PURPOSE AND MISSION

To provide quality dental care to inmates/residents in a cost effective manner under the direction of state licensed dentists and adhering to the guidelines, if any, set forth by the contracting clients.

The primary mission of Dental services shall be the prevention, control, and correction of oral conditions which are detrimental to the health of the inmate/residents or impose a hardship in the rehabilitation of the inmates/residents.

D-001 ORAL CARE

APPROVED BY:
Wexford Health Sources, Inc. Medical Advisory Committee

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APPROVED DATE: May 26, 2006
REVIEW DATE: September 1, 2007
LAST UPDATED:

I. WEXFORD, ACA, AND NCCHC STANDARD

Oral care under the direction and supervision of a dentist licensed in the state will be available to each inmate/resident. Care shall be timely and includes immediate access for urgent or painful conditions.

II. WEXFORD COMPLIANCE INDICATORS

A. All aspects of the above mentioned standard should be addressed by site specific written policy and defined procedures.

B. Oral screening by the dentist or qualified health care professionals trained by the dentist will be performed within 7 days (Prisons and Juvenile) or 14 days (Jails) of admission to the correctional system.

C. Instruction in oral hygiene and preventive oral education will be given within one (1) month (Prisons and Jails) or 14 days (Juvenile) of admission.

D. An oral examination will be performed by a dentist within 30 days (Prison), 60 days (Juvenile), or 12 months (Jails) of Admission.

E. Oral treatment, not limited to extractions will be provided according to a treatment plan based upon a system of established priorities for care (Refer to treatment priority classification)

F. Radiographs will be appropriately used in the development of the treatment plan.

G. Consultation through referral to oral health care specialists will be available as needed.

H. Each inmate will have access to the preventive benefits of fluorides (in accordance with facility policy) and in a form determined by the dentist to be appropriate for the needs of the individual.

I. Where oral care is provided on site, contemporary infection control procedures will be followed.

J. Routine dental problems will be managed in a timely fashion in keeping with current community standards of practice

III. DEFINITIONS

A. Oral care includes instructions in oral hygiene, examination, and treatment of dental problems. Instruction in oral hygiene minimally includes information on plaque control and the proper brushing of teeth.

B. Oral screening includes visual observation of the teeth and gums and notation of any obvious or gross abnormalities requiring immediate referral to a dentist.

C. Oral examination by a dentist includes taking or reviewing the patient's oral history, and extra oral head and neck examination, charting of teeth, examination of the hard and soft tissue of the oral cavity with a mouth mirror, explorer, and adequate illumination, and taking and reading any necessary radiographs.

D. Oral treatment includes the full range of services that in the supervising dentist's judgment are necessary for proper mastication and maintaining the inmate's/resident's oral and general health status.

Oral treatment includes but is not limited to:

1. X-rays
2. Restorations (fillings)
3. Treatment of infections
4. Oral surgery (i.e. extraction of infected and non-restorable teeth)
5. Emergency treatment
6. Post-operative treatment
7. Non-surgical periodontal services
8. Prosthetic devices including dentures and partials and repairs.
9. Limited endodontic therapy (root canal therapy)
10. Oral hygiene instructions, dental health education, and appropriate follow up procedures.

E. Infection Control practices are defined by the American Dental Association and the Center for Disease Control and Prevention as including sterilizing instruments, disinfecting equipment, and properly disposing of hazardous waste.

F. Regional Dental Director is a dentist licensed in the state where the dental services are provided and is responsible for the programmatic/clinical supervision of statewide or regional dental services.

G. Institutional or Site Dental Director is a dentist licensed in the state where the dental services are provided and is responsible for the programmatic/clinical supervision of dental services at any facility (site) dental clinic.

H. Dental Coordinator is the trained and licensed individual responsible for the administrative coordination of a site's dental clinic operations and assisting the dentist with the examination and treatment of the inmate/resident patients.

I. Dental Hygienist is the licensed individual who, along with dentists and dental coordinators, is responsible for providing preventive education in oral hygiene in addition to providing treatment for periodontal problems, and follow-up appointments for periodontal maintenance on the inmate/resident patients.

IV. PRIORITIZING DENTAL CARE

Priority of comprehensive dental services should be established by oral examination and implementation of a classification system. The findings from the oral examination which includes a periodontal score should be analyzed to arrive at a generalized categorization or classification.

Basic dental care can be categorized as:

A. Elective care

B. Corrective care

C. Interceptive care

D. Urgent care

E. Emergency care

Using the above criteria as a starting point, the classification of dental patients should be based upon the following generalized factors:

V. CLASSIFICATION I

Patients presents with incipient or no tactical or radiographically observable caries. The patient's periodontal condition would be classified as code 1 (gingivitis) or code 0 (none). Patients meeting these criteria shall be classified as Type I.

These patients should be scheduled and any therapy begun within twenty four (24) months of entering the system. However all therapy should be provided within the shortest time frame practicable.

VI. CLASSIFICATION II

Patient presents with tactically determined cavitations due to caries or cavitation observable radiographically and/or may present with code 3 (moderate) periodontal disease in one or more sextants and/or code 2 (early) periodontal diseases in three or more sextants.

Patients meeting these criteria shall be classified as Type II. These patients should be scheduled and therapy begun within twelve (12) months of entering the system.

However all oral surgery, non-surgical periodontal therapy and restorative services should be provided within the shortest time frame practicable.

VII. CLASSIFICATION III

Patient presents with frank observable cavitations due to caries, code 4 (Advanced) periodontal diseases in one or two sextants and/or code 3 (moderate) periodontal disease recorded in three or more sextants and/or conditions to warrant removable prosthodontic therapy to restore masticatory function. It cannot be immediately determined that immediate extraction is the treatment required for the caries and/or periodontal disease. Patients meeting these criteria shall be classified as Type III.

These patients should be scheduled and therapy begun within ninety (90) days of entering the first receiving facility. All oral surgical, non-surgical periodontal therapy, restorative services, and rehabilitative procedures should be accomplished within the shortest timeframe practicable.

VIII. CLASSIFICATION IV

Patient presents with gross observable cavitation due to caries or code 4 (Advanced) periodontal disease recorded in three or more sextants. The caries and/or periodontal condition require the immediate extraction of one or any number of teeth.

*Each state/region may have individual variances and a copy of those variances should be attached to this policy.

Also, the patient may require antibiotic therapy prior to the oral surgery. This urgent condition should be classified as Type IV.

These patients, ideally, should be treated at the initial intake facility if at all practical and possible.

When the immediate extractions have been accomplished at the initial intake facility, the patient can be reclassified as appropriate prior to being assigned to their fist facility. If the patient is reassigned prior to completion of the necessary extractions, the receiving facility must schedule and initiate therapy as quickly as possible upon inmate entry.

The patient should be kept on an active treatment list after reclassification if necessary to complete treatment. All oral surgical, non-surgical periodontal therapy, restorative services, and rehabilitative procedures should be accomplished within the shortest time frame practicable.

IX. CLASSIFICATION V

Patient presents with obvious active infection, edema (possible developing cellulites), pain, or obvious suspicious oral neoplasm. This is the true emergency patient and should be classified as Type V.

These patients **must** be initially treated at the initial intake facility. **They may not be reassigned to another facility pending the resolution of the infection or the outcome of the diagnostic biopsy.**

When the oral condition has been stabilized the patient is reclassified as appropriate. It should be obvious that patients with extensive, active dental disease should not be assigned to a facility that does not have a dental clinic, but instead should be assigned to a facility with adequate dental coverage.

D-002 GENERALIZED PROCEDURE GUIDELINES

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APPROVED DATE: May 26,2006
REVIEW DATE: September 1, 2007
LAST UPDATED: March 18, 2008

1. GENERALIZED PROCEDURE GUIDELINES

The following clinical procedure guidelines offer only the basic recommendations for dental services. Services must be rendered within the limits governed by the facilities (Juvenile, Jails, Adult Prisons) and the limited resources of dental services per client contract.

In general the following dental guidelines apply:

A. Dental examinations

Initial examinations with panoramic x-ray and bitewing x-rays, followed by biennial exams (every two (2) years) and biennial bitewings and panoramic x-ray every five (5) years.

B. Emergency treatment (self explanatory)

C. Restorative Dentistry

Routine restoration of teeth without nerve exposure will be provided. Restoration will be done with fillings of amalgam material for posterior teeth and composite resin material for anterior teeth.

D. Oral Surgery

Extraction of teeth which are not restorable due to infection, decay, periodontal disease, or trauma will be provided. Most oral surgery procedures will be performed by the staff dentist. This will include routine extractions, alvedectomies, bone reduction, cyst removal, biopsies, and impactions, within the limits of the individual operator's proficiency. The more difficult cases should be referred to oral surgeons. Collegial review between the Site Dental Director and Regional Dental Director should occur before routine off-site oral surgery is scheduled. Emergency off-site oral surgery should follow written site policy, per security and medical protocols.

E. Periodontal treatment

Non-surgical treatment of gum disease will be provided. This consists of deep cleaning (sub gingival scaling, root planning, gingival curettage). Teeth with severely advanced periodontal disease will not be treated.

Routine dental cleanings shall be provided within the limits of the resources of Dental Services.

F. Endodontic treatment (Root canal)

Endodontic therapy shall be limited to front teeth which have good periodontal support and enough remaining tooth structure to restore. Exceptions for endodontic therapy are at the discretion of the facility dentist.

G. Removable Prosthetics

1. Full Dentures

Inmates/residents entering the system with no teeth and no dentures, who will be incarcerated at a facility for longer than six (6) months from the start of making a denture, will be provided a denture (s) if they request the service. Inmates/residents who have all their teeth extracted, for clinical reasons, while incarcerated at a facility, and who will be incarcerated for longer than six (6) months from the start of making a denture, will be provided dentures if they request the service. Dentures will not be remade more frequently than every five (5) years and only when clinically necessary.

2. Partial Dentures

Partial dentures will only be provided to inmates/residents to restore incising and masticatory function and only if the responsible dentist determines that the inmates/resident's health and/or rehabilitation would otherwise be adversely affected.

When such devices are contraindicated for security reasons, the Dentist and Health Services Administrator will work in conjunction with the facility administration to try to obtain alternatives so the oral health needs of the inmate/resident are met.

Partial dentures will only be made if the inmate/resident will be incarcerated for longer than six (6) months from the start of making the partial denture and the service is requested. Partial dentures will not be made more frequently than every five (5) years and only when clinically necessary.

Partial dentures will only be made after all other dental work is complete and the inmate/resident demonstrates good oral hygiene.

H. Fixed Prosthetics

1. Crowns and Bridges

No cast (precious or non precious metal) or porcelain crowns or bridges will be provided under any circumstances. The cost of fixed prosthetics in terms of provider time and appliance materials precludes their use in the corrections environment.

Inmate/residents entering the system with existing crowns or bridges may have them recemented if they come off and if the underlying tooth structure is healthy. Otherwise acrylic crowns or stainless steel crowns will be used for badly broken down teeth.

I. Orthodontics (Braces)

No orthodontic treatment shall be provided. Inmate/residents entering the system with existing braces will be given the option of removal of their braces by a staff dentist. Exceptions for this guideline will occur with some short time inmates/residents at juvenile facilities and jails. In these situations written site policies will dictate alternative treatment services.

J. Sports or Night Guards

No sports or night mouth guards will be routinely provided to the inmates/residents. In unusual cases, occlusal splints may be provided for cases involving extreme bruxism (grinding of teeth) or diagnosed temporal-mandibular joint dysfunction. Collegial review between the site and Regional Dental Directors should occur before any appliance fabrication occurs.

D-003 DENTAL SICK CALL REQUESTS

APPROVED BY:
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APPROVED DATE: December 11, 2006
REVIEW DATE: September 1, 2007
LAST UPDATED:

I. POLICY

Inmates/residents seeking dental treatment should use a state and/or corporate approved dental sick call request form to have their requests prioritized so treatment can be scheduled accordingly.

Once a written request is received, the inmate's/resident's dental chart should be reviewed along with the medical history to determine the priority level of the request. This chart review should be conducted by the staff dentist, dental coordinator (assistant) or, in their absence, by the medical (nursing) staff according to site-specific written protocol.

II. SCHEDULING PROCESS

A. Emergency care receives the top priority. Care for inmates/residents with true dental emergencies shall be available at all times, either through the dental department or the medical staff at each facility. Emergency dental care consists of:

1. Relief of severe pain
2. Control of bleeding
3. Treatment of acute infection
4. Treatment of injuries to the teeth supporting structures

These true emergency individuals are scheduled before anyone else on a daily clinical basis. Medically compromised individuals in this group may dictate consultation with the medical staff to develop a clinical resolution to the emergency dental problem.

B. Urgent care receives second priority for scheduling and includes any dental scenario that could quickly evolve into an emergency situation if not treated on a timely basis. These individuals too, if medically compromised, may require consultation with the medical staff to develop a clinically acceptable solution to their dental problem.

C. Corrective care or treatment going forward from a pre-diagnosed treatment program should receive third priority scheduling consideration. These dental sick call requests come from individuals who know or have been told of dental treatment needs and send in requests to begin, continue, or finish treatment. These requests must be reviewed and even though the situation is not emergent or urgent, the individual should be placed on a treatment list if he/she has not already been placed on the list from the intake screening at their current facility.

D. Interpretive care must be given a fourth priority when considering the schedule. These appointments usually involve recall checkups and biennial exams and x-rays. These appointments are necessary but should not take precedence over any emergent or urgent requests.

*Each state/region may have individual variances and a copy of those variances should be attached to this policy.

III. SUMMARY

The process for prioritizing dental sick call requests should consider all the preceding information and the final determination of scheduling must be made based upon the professional judgment of the clinical staff.

*Each state/region may have individual variances and a copy of those variances should be attached to this policy.
Approved by the Wexford Medical Advisory Committee 05/26/06; 09/01/07; 10/08

CONCLUSION

Dental clinical situations not covered by the aforementioned guidelines should be resolved by the site dental director and if necessary through the utilization of collegial review and consultation with the regional dental director.

Dental treatment for the medically compromised inmate/resident must involve consultation with the site medical staff to develop a clinically acceptable protocol for providing dental services.

These policies do not replace sound clinical judgment; nor are they intended to strictly apply to all patients.

*Each state/region may have individual variances and a copy of those variances should be attached to this policy.
Approved by the Wexford Medical Advisory Committee 05/26/05; 09/01/07; 10/08

ORAL AND MAXILLOFACIAL SURGERY GUIDELINES

ORAL & MAXILLOFACIAL SURGERY

DX	Primary (Unit) Rx	Secondary (Wexford) Rx *Unless emergent, conduct collegial review.
Acute Infections of the Oral Cavity	Pain, swelling, trismus, elevated temperature, airway compromise, dysphasia, elevated tongue Rx: Airway security antibiotics, incision and drainage, culture, sensitivity, gram stains	Refer Emergent if airway involved. May warrant possible referral to OS for biopsy, excisions
Dental Caries involving pulp, periodontal disease	Pain, thermal sensitivity, tooth mobility, cellulites/abscess Rx: Antibiotics, extraction, refer to restorative dentistry, endodontics if indicated	Refer to Endodontist only if complicated endodontics is involved, the tooth is crucial to arch integrity, there is a good periodontal support and a long incarceration is expected.
Impacted Molars Symptomatic	Pain, pressure, shifting teeth pericoronitis, cysts, dysphagia, asymptomatic Rx: Antibiotics, X-ray diagnosis, surgical extraction	Refer Routine if not able to do at unit or Urgent if infected.
Fractured teeth with or without pulp exposure	Pain, thermal sensitivity Rx: Refer for restorative dentistry, endodontics, extractions	None
I. Fracture of Mandibular body and ramus fractures	Pain, swelling, malocclusion, bleeding, motor/sensory nerve deficits Rx: Refer to Oral Surgery	Refer Urgent for reduction and immobilization
II. Mandibular condyle	Trismus, open bite, mandibular deviation, pain, swelling, malocclusion Rx: Refer to Oral Surgery	Refer Urgent for reduction and immobilization
III. Traumatic injuries of teeth and Alveolar process	Gingival laceration, mobile alveolar segment, pain, malocclusion, bleeding Rx: Tooth refosetion, splinting, surgical removal of alsetor segment	Refer to OS if beyond capability of the unit
IV. Maxilla (Lefort Fractures)	Mobility of maxilla, visual changes, motor/sensory deficits, periorbital ecchymosis, pain, swelling, malocclusion Rx: Refer to Oral Surgery	Refer Urgent for reduction and immobilization
V. Orbit, blow out fractures	Restricted eye movement, visual changes, motor/sensory deficits, periorbital ecchymosis, pain, swelling Rx: Refer to Oral Surgery	Refer Urgent for orbital exploration and reconstruction

DX	Primary (Unit) Rx	Secondary (Wexford) Rx *Unless emergent, conduct collegial review.
VI. Naso-orbital-ethmoid complex	Epistaxis, cerebral spinal rhinorrhea, nasal dysfunction, telechanthus, visual changes, facial asymmetry, motor/sensory deficits, pain, swelling Rx: Refer to Oral Surgery	Refer Urgent for reduction and immobilization, orbital exploration and reconstruction
Mandibular condyle dislocation	Open lock, pain Rx: Reduction with/without immobilization Refer to Oral Surgery if unable to reduce	Refer Urgent for reduction
Traumatic injuries to soft tissue of head and neck	Lacerations, pain, swelling, bleeding, tissue emphysema, motor/sensory deficit, cosmetic injury Rx: Multi-layered closure and dressing Refer to Oral Surgery if beyond capabilities of unit	Refer Urgent for reduction and immobilization if fractures are present or within 24 hours to sutures lacerations.
Osteomyelitis maxilla/mandible	Pain, swelling, pathologic fracture, motor/sensory nerve deficit Rx: IV antibiotics (define), culture, sensitivity, gram stain, debridement, wound care, and hyperbaric oxygen. Refer to Oral Surgery	Refer Urgent
Osteoradionecrosis of maxilla/mandible	Pain, swelling, bone exposure pathological fracture Rx: Wound care, IV antibiotic (define), hyperbaric oxygen, debridement and bone grafting. Refer to Oral Surgery	Refer Urgent
Maxillary/mandibular discontinuity bony defects	Unable to fabricate dentures Rx: Mandibular and maxillary tori reduction.	Refer Routine if beyond capabilities of the unit.
Temporomandibular joint disease	Pain, restricted mandibular opening, malocclusion, clicking crepitus in opening and closing Rx: Conservative TX muscle relaxants, fabrication of interocolusal splints.	Refer Routine or Urgent if "closed lock" is present or for severe pain
Benign or malignant pathology of the jaws and adjacent area	Pain, swelling, displacement of teeth, bone expansion, radiopaque/radiolucent lesions, pathological fracture, motor/sensory nerve deficits, metastatic changes Rx: X-ray evaluation, R/O Metastatic Disease, needle aspiration, biopsy, definitive surgery. Refer to Oral Surgery	Refer Urgent for surgical treatment
Complicated Exodontia	Oroantral communications, iatrogenic fractures.	Refer to OS.